WESTERN WASHINGTON MEDICAL GROUP

Emily Huang, M.D.
Mark Gunning, M.D., M.R.C.P.
DEPARTMENT OF NEPHROLOGY
1330 ROCKEFELLER, SUITE 450 • EVERETT, WA 98201

Telephone No.
Office: (425) 258-6801
Fax: (425) 258-1944

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

PLEASE PRINT

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

CONSTITUTIONAL

Recent weight change	No	Yes
Fever	No	Yes
Night sweats or chills	No	Yes
Fatigue	No	Yes
Daytime drowsiness	No	Yes
Changes in sleep	No	Yes

EYES

Eye disease	No	Yes
Dry eyes	No	Yes

ENT

Sinus problems	No	Yes
Persistent hoarseness	No	Yes
Post-nasal drip	No	Yes
Runny nose	No	Yes
Seasonal allergies	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain	No	Yes
Rapid / Irregular heartbeat	No	Yes
Heart murmur	No	Yes
Swelling feet or ankles	No	Yes
History of blood clots	No	Yes
History of rheumatic fever	No	Yes

RESPIRATORY

Frequent cough	No	Yes
Sputum production	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
History of tuberculosis	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Stomach ulcers	No	Yes
Gastric reflux / heartburn	No	Yes
Liver problems / hepatitis	No	Yes

GENITOURINARY

Burning or painful urination	No	Yes
Kidney problems	No	Yes
Blood in urine	No	Yes
Frequent urinary infections	No	Yes

MUSCULOSKELETAL

Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Difficulty walking	No	Yes

SKIN

Rash	No	Yes
Persistent itching	No	Yes

NEUROLOGICAL

Frequent headaches	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Stroke	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes

ENDOCRINE

Thyroid disease	No	Yes
Diabetes	No	Yes

HEMATOLOGIC / LYMPHATIC

Easily bruising or bleeding	No	Yes
Anemia	No	Yes

ALLERGIC / IMMUNOLOGIC

Medication allergies	No	Yes
Food allergies	No	Yes

Date ______________________

Patient Signature: ______________________ Physician Signature: ______________________

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PATIENT HISTORY QUESTIONNAIRE

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PATIENT NAME: ______________________ DATE OF BIRTH: ____________

REASON FOR VISIT / CURRENT COMPLAINT

DR'S NOTES (DO NOT WRITE IN THIS SPACE)

Please list any hospitalizations, including date / reason for hospitalizations (Surgeries / Illness)

Type of Surgery	Year	Medical Hospitalizations	Year

Please List all current medications:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please list any medications you are allergic to and what happens when you take them.

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